

10-088

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

RECEIVED**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

JAN 03 2011

This Section must be completed for all projects.

**HEALTH FACILITIES &
SERVICES REVIEW BOARD****Facility/Project Identification**

Facility Name: Hispanic American Endoscopy Center		
Street Address: 3536 West Fullerton Avenue		
City and Zip Code: Chicago, Illinois 60647		
County: Cook	Health Service Area 006	Health Planning Area:

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Ramon Garcia, M.D.
Address: 3536 West Fullerton Avenue, Chicago, Illinois 60647
Name of Registered Agent:
Name of Chief Executive Officer:
CEO Address
Telephone Number: 773-772-1212

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
	<input checked="" type="checkbox"/> Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli Shughart PC
Address: 161 North Clark Street, Suite 4200, Chicago, Illinois 60601
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number: 312-873-2939

Additional Contact

[Person who is also authorized to discuss the application for permit]

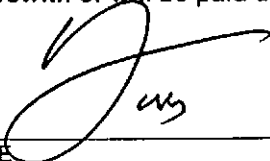
Name: Ramon Garcia, M.D.
Title: Medical Director
Company Name: Hispanic American Endoscopy Center
Address: 3536 West Fullerton Avenue, Chicago, Illinois 60647
Telephone Number: 773-772-1212
E-mail Address: N/A
Fax Number: 773-772-8666

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Ramon Garcia, M.D. * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.



SIGNATURE

Ramon Garcia, M.D.

PRINTED NAME

PRESIDENT

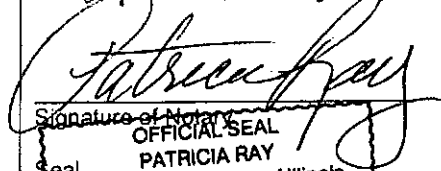
PRINTED TITLE

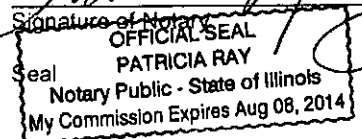
SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24 day of Dec. 2010





Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert EXACT legal name of the applicant